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CABINET FOR HEALTH AND FAMILY SERVICES
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JAMES W. HOLSINGER, JR., M.D.
SECRETARY

July 30, 2004

Nursing Facility Provider Letter #A-207

Dear Nursing Facility Provider:

The Department for Medicaid Services (DMS), in conjunction with the nursing facility industry, have been working to rebase the nursing facility standard price system for the July 1, 2004 rates. We are pleased to inform you that an agreement has been reached and funding has been made available through the increase in the provider assessment. The following represents a summary of the final provider assessment amounts and the rebased standard price.

Provider Assessment
DMS and the associations worked diligently to arrive at an agreeable provider assessment that would comply with the rules and regulations required by the Centers for Medicare and Medicaid Services.

The provider assessment in accordance with KRS Chapter 142 payable on the 20th day of the due month is as follows:

- Assessment per non-Medicare day for hospital based providers = $3.00.
- Assessment per non-Medicare day if total annual census days are greater than 60,000 days = $6.80.
- Assessment per non-Medicare day if total annual census days are less than or equal to 60,000 = $10.60.

Annual census days will be determined from the latest NF Medicare cost report on file as of June 1st of the prior rate year and is subject to audit at the Department's discretion.

Standard Price Rebasing
The standard price was updated to reflect rebased wages. The wage and non-wage components of the standard price were also inflated by 2.3% to reflect inflation through SFY 2005. The non-wage components of the standard price were also inflated by 2.85% to reflect rebasing. In addition, the rebasing agreement also included moving all providers to the standard price effective July 1, 2004.

In accordance with 907 KAR 1:065 the rebased standard price (excluding facility-specific capital) effective July 1, 2004 is as follows:

	Urban	Rural
Case Mix Adjusted Cost Component	$ 78.24	$ 64.58
Non-Case Mix Adjusted Cost Component	$ 54.62	$ 48.02
Facility Costs	$ 4.22	$ 4.22
Total Standard Price	$137.08	$116.82

Q. Will providers continue to pay the existing 2% provider tax?

A. The provider assessment described in the letter replaces the previous provider assessment, which was based on a percentage of revenue. Providers will continue to report revenues in accordance with CMS requirements, but providers will only pay the assessment on non-Medicare days effective July 1, 2004 and forward.

Q. When will the providers receive increased reimbursements generated by the provider assessment?

A. The attached rate worksheet incorporates the funding generated by the provider assessment. These funds were utilized to rebase the standard price components and provide inflation increases. Providers will receive the increased reimbursements when they bill services for the month of July 2004.

Q. Is the required monthly form complicated? Will a provider need a CPA to complete the form?

A. The monthly form is nearly identical as the form previously required. The only change to the form is that non-Medicare days are also included on the form and it must be reported monthly to the Department of Revenue. A CPA will not be needed to complete the form.

Q. Are there any special spending requirements attached to the funds generated by the rate increases?

A. The additional revenue was used to:

- Fully phase-in those providers whose current rates are less than the Medicaid price-based rates;
- Correct for inflation adjustments for the past two (2) years; and
- Rebase the rates to recognize current wage and benefit levels in the industry.

In addition to the standard price amounts above, the facility-specific capital appraisal amount as of June 30, 2004 will be added to each provider's rate to arrive at the July 1, 2004 per diem for the capital component. The case mix adjusted component of the standard price is adjusted by the facility case mix index to arrive at the facility-specific rate.

Enclosed is a copy of the price-based rate worksheet for your facility. This rate is effective July 1, 2004. Also, enclosed are the resident roster and delinquent report for residents in your facility as of March 31, 2004, based on assessments received as of June 30, 2004.

An appeal of these rates may be requested in accordance with 907 KAR 1:065 Section 14, "A price-based nursing facility may appeal a department decisions as to the application of this administrative regulation in accordance with 907 KAR 1:671." The appeal request, whether for a resolution meeting or administrative hearing, must be in writing and addressed to the Director, Division of Long Term Care and Community Alternatives, Department for Medicaid Services, Cabinet for Health and Family Services, 275 East Main Street, 6W-B, Frankfort, Kentucky 40621-0001, and received, in hand, by the Department within thirty (30) days from the date of this letter. The appeal process involves two steps: (a) a resolution meeting may be requested and held or, in lieu of a resolution meeting, the provider may submit written information to the Department it wishes considered in relation to the Department's determination, and/or (b) an administrative hearing conducted by an administrative hearing officer if the provider disagrees with the decision rendered by the Department as a result of the resolution meeting or submission of written information, or if the provider wishes to skip the first level appeal process. All appeal requests shall identify the disputed issues, the basis on which the Department's decision is believed to be erroneous, provide documentation supporting the provider's position, and the name, address, and telephone number of individuals expected to attend the resolution meeting on the provider's behalf. A request which does not specify the exact item(s) being appealed or otherwise comply with 907 KAR 1:671, Sections 8 and 9, shall not be accepted. You are responsible for any copies of this material that your agency/corporation may require.

Should you have any questions regarding the July 1, 2004 rates please contact the Medicaid rate setting contractor representative, Brad Blunt of Myers and Stauffer LC at 888/749-5799 or 502/695-6870.

Sincerely,

Gina Oney
Acting Director

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Enclosures

The Department for Medicaid Services (DMS) worked in collaboration with the nursing facility industry to provide a list of questions and answers regarding the provider assessment fee. We believe this list should answer most of your questions. However, should you need further clarification or have additional questions please contact Wayne Johnson with KAHCF at (502) 425-5000 or Tim Veno with KAHSA at (502) 992-4380.

Frequently Asked Questions

Q. What is the actual rate increase that providers will see as a result of the provider assessment fee?

A. Due to changes in case mix and other variables, the actual rate changes are not the same for all providers. Nursing facility providers will need to calculate their own rate change based on the attached rate worksheet.

Q. What is the due date of the provider assessment fee each month?

A. The provider will be required to report their revenue and non-Medicare days on a monthly basis, which should be postmarked by the 20th day for the previous month's billing.

Q. What does the assessment fee apply to and what is the effective date?

A. The assessment applies to all non-Medicare days from the previous month's billing period. The assessment is effective July 1, 2004. Therefore, providers will be reporting July 2004 revenue and non-Medicare days to the Department of Revenue in the month of August 2004, and each month thereafter for the proceeding month's revenue and non-Medicare days.

Q. What is the process for paying the provider assessment?

A. Beginning in August 2004, providers will report the amount of revenue and non-Medicare days from the previous billing month to the Department of Revenue. Providers will continue to submit the provider assessment form and remittance as before. As noted in the letter, the provider assessment amount is as follows:

- Assessment per non-Medicare day for hospital based providers = $3.00.
- Assessment per non-Medicare day if total annual census days are greater than 60,000 days = $6.80.
- Assessment per non-Medicare day if total annual census days are less than or equal to 60,000 = $10.60.

The provider assessment amount will be determined based on non-Medicare days from the latest NF Medicare cost report on file as of June 1st of the prior rate year. The provider assessment rate will be determined based upon total annual census days from these same cost reports. You will be notified by the Department if the total annual census days exceed 60,000, thereby qualifying for the $6.80 per non-Medicare day rate. Patient days reported on both the cost reports and the monthly assessment forms are subject to audit at the discretion of the Department.